

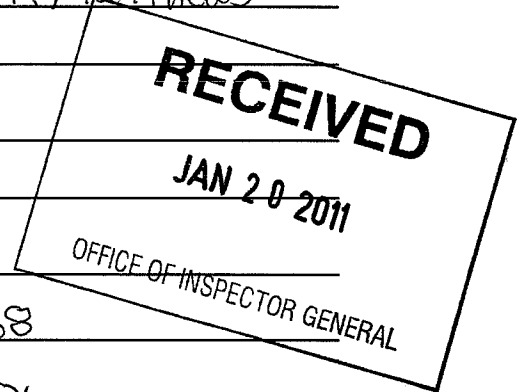
**Application for License to
Operate a Long-term Care Facility**

For Office Use Only
Received 1/20/11
Amount 1875.00

GGNSC Administrative Services, LLC #81143759

I. IDENTIFICATION

Name Golden Living Center St. Matthews
Address 227 Browns Lane
City/County/Zip Louisville 40207
Telephone number 502-893-2595
Administrator Josh Schwabler
Date facility operation began at current address 1968
Date facility began operation under current owner 2006



II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>125</u>	<u>125</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State	<u>Profit</u>	Individual
County	Nonprofit	Partnership
City		<u>Corporation</u>
<u>Private</u>		<u>LLC</u>

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

GGNSC Louisville ST. Matthew's LLC
1000 Finance Way
Fort Smith 72919

(OVER)

12/31

If facility owned or leased by a corporation, complete the following:

Name of corporation GGNOSC

Address of corporation 1000 Fianwa Way, Fort Smith AR 72919

President or Chairman Larry Deans

Vice President Kevin Roberts, Larry Joseph, John Brubaker, David Morrell

Secretary Holly Jones

Treasurer Ann Pruitt

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent

Management Company

1000 Fianwa Way
Fort Smith, AR 72919

N/A

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

John E. Schuler
Signature of authorized representative

Executive Director 1/10/11
Title Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)